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Issue Date: 12 April 2007

In the Matter of:
R.B.
Claimant

v. Case No. 2006-BLA-05035

CONSOLIDATION COAL COMPANY,
Employer

And

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Joseph Wolfe, Esquire
For the Claimant

Ashley Harman, Esquire
For the Employer

Before: DANIEL F. SOLOMON
Administrative Law Judge

DECISION AND ORDER ON MODIFICATION
AWARDING BENEFITS

This case arises from a claim for benefits under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq*. (hereinafter referred to as "the Act"), and applicable federal regulations, mainly 20 C.F.R. Parts 412, 718, and 727 ("Regulations").

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.[1]

At a hearing conducted in Abingdon, Virginia on March 15, 2006, all parties were afforded a full opportunity to present evidence and argument, as provided in the Act and Regulations issued thereunder, found in Title 20, Code of Federal Regulations. The Director's exhibits 1-177, Claimant's exhibits 1 to 2, and Employer's exhibits 1-48 were admitted into

[1] The following abbreviations have been used in this decision: DX = Director's exhibit; EX = Employer's exhibit; CX = Claimant's exhibit; Tr. = Transcript of the hearing; BCR = Board-certified radiologist; and B = B reader of x-rays.

evidence without objection. Tr. 5,13,25. The parties were given thirty days to submit closing arguments, Dr. DePonte's deposition transcript (CX 3) and the signature page from Dr. Repsher's deposition were sent to me post hearing and are admitted. Tr. 22-23, 26.

ISSUES

The contested issues are:

1. Whether Claimant has (complicated) pneumoconiosis;
2. Whether the pneumoconiosis arose out of Claimant's coal mine employment;
3. Whether the miner is totally disabled due to pneumoconiosis; and
4. Whether the miner has established a change in condition pursuant to 20 C.F.R. 725.310 (modification);
5. Whether there was a mistake in a determination of fact pursuant to 20 C.F.R. § 725.310.

APPLICABLE STANDARDS

Because the Claimant filed this application for benefits after March 31, 1980, the regulations set forth at part 718 apply. This claim is governed by the law of the United States Court of Appeals for the Fourth Circuit, because the Claimant was last employed in the coal industry in the Commonwealth of Virginia within the territorial jurisdiction of that court. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989) (en banc).

To receive black lung disability benefits under the Act, a miner must prove that (1) he suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) he is totally disabled, and (4) his total disability is caused by pneumoconiosis. *Gee v. W.G. Moore and Sons*, 9 B.L.R. 1-4 (1986) (en banc); *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65 (1986) (en banc). *See Mullins Coal Co., Inc. of Virginia v. Director, OWCP*, 484 U.S. 135, 141, 11 B.L.R. 2-1 (1987). The failure to prove any requisite element precludes a finding of entitlement. *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111 (1989); *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986) 1-1 (1986) (en banc).

A Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production; the obligation to come forward with evidence to support a claim. Therefore, the Claimant cannot rely on the Director to gather evidence. The Claimant bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

STIPULATIONS AND WITHDRAWAL OF ISSUES

1. The Claimant is a miner and worked after 1969 in coal mine employment. TR 10.
2. Consolidation Coal Company is the responsible operator. TR 11.

I have reviewed all of the evidence in the record and I accept the stipulations as they are consistent with the evidence.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History and Factual Background[2]

Procedural History

Claimant filed this claim for benefits on April 19, 1996. (DX 1). The District Director awarded benefits on December 18, 1996, and Employer requested a hearing before the Office of Administrative Law Judges. (DX 35, 39). By Decision and Order dated November 10, 1997, Administrative Law Judge Stuart A. Levin denied benefits. (DX 59). Claimant appealed to the Benefits Review Board ("the Board"), which affirmed the denial in a Decision and Order on November 19, 1998. (DX 60, 61, 64). Claimant requested modification and the District Director denied the request for modification on June 23, 2000 in a Proposed Decision and Order. (DX 65, 84). Claimant appealed the District Director's decision and the case was forwarded to the Office of Administrative Law Judges for hearing. (DX 86, 93). On June 11, 2002, Administrative Law Judge Edward Terhune Miller denied benefits. (DX 136).

Claimant again appealed to the Board, which issued a Decision and Order Affirming Rejection of Claim on June 30, 2003 (DX 137, 140). Claimant then filed the current request for modification which was ultimately denied by the District Director on July 13, 2005, following a request for reconsideration of the initial denial and in response to other filings by the parties. (DX 144, 147, 153, 166). Claimant then requested a hearing before the Office of Administrative Law Judges and the file was transferred to this office. (DX 172, 174, 175). A formal hearing was held on March 15, 2006.

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented. Where pertinent, I have made credibility determinations concerning the evidence.

Background

At the hearing, Claimant testified as follows: He never smoked or had asthma in his lifetime, has never been around any kind of farm situation, and has had two negative tuberculosis tests. Tr. 14-15. Claimant testified that he was a foreman, was the foreman over blasting, and was the driller and certified blaster. Tr. 15-16. He testified that Dr. Patel has been his treating physician since January 2004 and that his situation has worsened since the last time he filed for modification. Tr. 15-16. Claimant explained that his breathing has worsened and has affected his ability to function as a married man, around the house, and in terms of getting a job. Tr. 16.

Claimant testified that he drilled through sandstone and the process was dusty with the dust sometimes rising 20-25 feet in the air. Tr. 18. Claimant testified that no one warned him that there was an inherent danger in drilling and that he had dry drills that were not equipped with water and did not have closed cabs. Tr. 20. Claimant testified that he has been told by doctors that he cannot go back to work and that he has complicated pneumoconiosis. Tr. 20-21.

Modification

The regulations provide that modification of an order may be sought at any time before one year after the denial of the claim. Specifically, the terms of an award or the decision to deny benefits may be reconsidered upon the showing of a "change in conditions" or a "mistake in a

[2] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718 (i.e., March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because the miner's last exposure to coal mine dust occurred in Virginia, this claim arises under the jurisdiction of the U.S. Court of Appeals for the Fourth Circuit *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998).

determination of fact." 20 C.F.R. § 725.310(a)(2000)(2001). In evaluating a request for modification, it is not enough that the administrative law judge conduct a substantial evidence review of the district director's finding. Rather, the parties are entitled to *de novo* consideration of the issue. *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156 (1990), *aff'd on recon.* 16 B.L.R. 1-71 (1992); *Dingess v. Director*, *OWCP*, 12 B.L.R. 1-141 (1989); *Cooper v. Director, OWCP*, 11 B.L.R. 1-95 (1988). In addition, even if a change in conditions is not established, evidence must be considered to determine whether a mistake in a determination of fact was made, even where no specific mistake of fact was alleged. *See O'Keeffe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971); *Jessee v. Director, OWCP*, 5 f.3d 723 (4th Cir. 1993); *Consolidation Coal Co. v. Director, OWCP [Worrell]*, 27 F. 3d 227 (6th Cir. 1994).

Previously, Administrative Law Judge Edward Terhune Miller found that Claimant did not establish the presence of complicated pneumoconiosis and did not establish that he is totally disabled due to pneumoconiosis. Specifically, in his Decision and Order–Rejection of Claim, Judge Miller found that the previous administrative law judge, Judge Levin, made a mistake in fact by failing to consider a chest x-ray showing complicated pneumoconiosis. However, after considering the entirety of the evidence in the record, Judge Miller found that this omission was harmless, and agreed with ALJ Levin that while the evidence established the presence of simple coal workers' pneumoconiosis arising out of the Claimant's coal mine employment, it did not establish the presence of complicated pneumoconiosis, and did not establish that Claimant is totally disabled due to a respiratory or pulmonary impairment. The Board affirmed Judge Miller's Decision and Order.

On modification, the District Director subsequently found that Claimant did not establish the existence of complicated pneumoconiosis or that he has a qualifying disability.

Accordingly, I will first determine whether Claimant has established a change in condition of entitlement and I will also evaluate whether Judge Miller made a mistake in a determination of fact pursuant to § 725.310, *O'Keefe*, and *Jessee*, *supra*.

In a petition for modification, *Rose v. Buffalo Mining Co*., 23 B.L.R. 1-___, BRB No. 06-0207 BLA (Jan. 31, 2007), the Board adopted the Director's position that the § 725.310(b) evidentiary limitations "supplement," rather than "supplant," the § 725.414 limitations. The Board reasoned:

> [W]here a petition for modification is filed on a claim arising under the amended regulations, each party may submit its full complement of medical evidence allowed by 20 C.F.R. § 725.414, i.e., additional evidence to the extent the evidence already submitted in the claim proceedings is less than the full complement allowed, plus the party may also submit additional medical evidence allowed by 20 C.F.R. § 725.310(b).

In order for Claimant to prove a change in conditions, the new evidence must be evaluated to determine whether Claimant suffers from complicated pneumoconiosis, or whether he is totally disabled due to coal workers' pneumoconiosis. As a result I find that there is good cause to use all of the evidence submitted to me for review.

Judge Miller's Decision and Order was dated July 17, 2002 and the Benefits Review Board Decision and Order is dated June 30, 2003. The Claimant requested modification in DX 141 and 142, in which new evidence from Drs. Aycoth and Cappiello was submitted. A Proposed Decision and Order was entered May 20, 2004. DX 153.

After considering the most recent evidence in the record, I find that Claimant has not established that he suffers from complicated pneumoconiosis, or that he is totally disabled, which are the elements of entitlement previously adjudicated against him. In addition, after evaluating

the medical evidence, I find that Judge Miller accurately summarized the evidence of record that was before him at the time and that he did not make a mistake of fact in finding that Claimant does not suffer from complicated pneumoconiosis and that he did not establish that he is totally disabled from a respiratory or pulmonary standpoint.

Medical Evidence

Chest x-rays

The record contains the following chest x-ray evidence submitted in connection with Claimant's request for modification:

Exhibit No.	Date x-ray	Physician/Qualifications	Interpretation
DX 19	02/24/86	Unknown (illegible)	1/2; r,u, 4z. Film quality 1.
DX 20	02/24/86	Bassali/BCR, B	1/1; r,u. Film quality 1.
DX 21	01/31/95	Coburn	1/1.
DX 22/147	01/31/95	Bassali/BCR, B	2/2; r,u. 4 z. Film quality 2.
DX 16	07/1/96	Forehand/B	1/1; q,q, 4 zones; A. Film quality 1.
EX 3	11/04/96	Wheeler/BCR, B	0/1; q,s. Minimal mixed small nodular and linear infiltrates in lateral periphery LUL, RUL, involving pleura with probable few tiny calcified granulomata lateral LUL or pleura compatible with TB unknown activity, partly healed. A few small nodules could be CWP but pattern is asymmetrical and peripheral rather than symmetrical small nodules in central mid and upper lungs. Film quality 2—light.
EX 4	11/04/96	Scott/BCR, B	No parenchymal or pleural abnormalities consistent with coal workers' pneumoconiosis. Peripheral upper lung fibrosis/infiltrates probably TB, unknown activity. Distribution of abnormalities makes silicosis CWP unlikely. Film quality 2—light.
EX 5	11/04/96	Scatarige/BCR, B	No parenchymal or abnormalities consistent with pneumoconiosis. Subpleural nodular infiltrates, L> R, some w/calcified granulomata. Favor TB, uncertain activity. Less likely sarcoidosis. CWP silicosis unlikely, since central lung regions are spared. Film quality 2—light.
EX 24	11/19/96	Repsher/B	1/2; t, q. ax. Probably not CWP. Film quality 2.
DX 147	1/08/97	Crawford	Interstitial fibrosis.
EX 6	01/08/97	Wheeler/BCR, B	No parenchymal or pleural abnormalities consistent with pneumoconiosis. Minimal linear interstitial fibrosis or interstitial infiltrate in lateral periphery upper lobes between anterior ribs 2-4 involving pleura mixed with possible few tiny nodules compatible with pneumonia, probably healed. Film quality 1.
EX 7	01/08/97	Scott/BCR, B	No parenchymal or pleural abnormalities consistent with pneumoconiosis. Peripheral upper lung linear and nodular infiltrates extending to the pleura, compatible with TB, unknown activity. This pattern is distinctly NOT that of silicosis/CWP. Film quality 1.
EX 8	01/08/97	Scatartige/BCR, B	No parenchymal or pleural abnormalities consistent with pneumoconiosis. Peripheral upper lobe infiltrate/fibrosis c/w TB of uncertain activity—need clinical correlation. Cannot not R/O due to sarcoidosis. No other abnormality. Film quality 1.
DX 147	06/24/99	Darlak	Chronic obstructive pulmonary disease.

EX 9 06/24/99 Wheeler/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Minimal linear interstitial fibrosis or interstitial infiltrate in lateral periphery upper lobes between anterior ribs 2-4 involving pleura mixed with possible few tiny nodules compatible with pneumonia, probably healed. Check for TB. Film quality 1.

EX 10 06/24/99 Scott/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Peripheral linear and nodular infiltrates upper lungs extending to pleura and likely containing a few calcified granulomata. Changes are probably due to TB, unknown activity. Film quality 1.

EX 11 06/24/99 Scatarige/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Peripheral subpleural infiltrates/fibrosis both upper lung zones, little changed from 1/97. Favor TB, probably healed, or sarcoidosis. No other abnormality. Film quality 1.

DX 99 01/05/01 DePonte/BCR, B 1/1; r,q; 6z; A

EX 28 08/28/01 Wheeler/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Minimal focal interstitial infiltrates or fibrosis lateral periphery upper lobes involving pleura between right anterior ribs 2-3 and left anterior ribs 2-4 compatible with inflammatory disease. Minimal degenerative arthritis T-spine with anterior wedging probably T8. Pattern is asymmetrical and peripheral involving pleura which favors granulomatous disease. No small symmetrical nodular infiltrates in central mid and upper lungs to suggest CWP but get CT scan for better evaluation.

EX 29 08/28/01 Scott/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Peripheral nodular and linear infiltrates with extension to and involvement of pleura both upper lungs: probably due to TB, unknown activity. Possible few calcified granulomata. Film quality 1.

EX 30 08/28/01 Scatarige/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Peripheral, subpleura nodular infiltrates/fibrosis C/W TB, unknown activity. Need clinical correlation; also could be sarcoidosis. Few calcified granulomata, ??? upper lobes. No small, scattered round opacities of CWP or silicosis.

EX 31 03/13/02 Wheeler/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Minimal linear and irregular interstitial infiltrates or interstitial fibrosis in lateral periphery, LUL > RUL. ECG leads. ILO classification was never intended for AP portable films. An exact diagnosis should be made on any interstitial lung disease to assure proper therapy. Film quality 2—improper position, scapulae on lungs on AP portable.

EX 32 03/13/02 Scott/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Upper lung bilateral infiltrates/fibrosis in periphery of lung, extending to pleura with pleural thickening. Changes probably TB, unknown activity. Film quality 3—light, improper position, scapulae over lungs.

EX 33 03/13/02 Scatarige/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Subpleural nodular infiltrates upper lobes C/W TB; sarcoid? Need clinical or tissue diagnosis. Few scattered calcified granulomata. Monitoring leads placed on chest wall. Film quality 2—improper position, poor contrast, low contrast, scapulae over upper lobes.

DX 151 11/18/02 McAdams Parenchymal lung disease may represent sarcoidosis, pneumoconiosis could have similar radiographic appearance. Please clinically correlate.
EX 12 11/18/02 Wheeler/BCR, B Unreadable—NIOSH does not allow classification of digital images. Minimal to moderate mixed linear-irregular interstitial fibrosis or interstitial infiltrates in lateral periphery upper lobes mixed with few tiny nodules and calcified granulomata compatible with TB unknown activity probably healed between anterior ribs 2-4. No pneumoconiosis but NIOSH does not allow ILO classification of even full scale digital images
EX 13 11/18/02 Scott/BCR, B Unreadable—Digital image not acceptable for classification. Peripheral upper lung linear and nodular infiltrates, probably with a few calcified granulomata. Infiltrates external to pleura. Changes are probably due to TB, unknown activity.
EX 14 11/18/02 Scatarige/BCR, B Unreadable—cannot classify digital images. Peripheral reticula nodular infiltrates/fibrosis upper and mid lung zones—likely due to TB since they extend to pleura. Doubt pneumoconiosis. Few calcified granulomata.
DX 142 09/12/03 Aycoth/B 2/1; q,t; 6z.
DX 142 09/12/03 Capiello/B 1/2; p,q.
EX 38 09/12/03 Wheeler/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Minimal irregular infiltrate or fibrosis left apex and lateral periphery LUL > RUL involving pleura with possible few small nodules compatible with granulomatous disease. Borderline enlargement left ventricle with CTR 16/32.5 and minimal tortuousity descending thoracic aorta and brachiocephalic artery. Check for hypertension. Few tiny scars in lateral mid lungs involving pleura near lower scapulae. Subtle degenerative arthritis T-spine. No symmetrical small nodular infiltrate in central mid and upper lungs to suggest CWP. Pleural involvement and irregular infiltrate or fibrosis favors granulomatous disease. Film quality 1.
EX 39 09/12/03 Scott/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Peripheral infiltrates and/or fibrosis upper lungs compatible with tb, unknown activity. Film quality 1.
EX 40 09/12/03 Scatarige/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Peripheral infiltrates/fibrosis in bilateral upper mid lungs sparing @ base; DDX: TB, histoplasmosis, sarcoid. Advise: CT lungs. No small, central round opacities of CWP/silicosis. Tortuousity of thoracic aorta; top normal heart size: CTR = 16/32.5. Film quality 1.
DX 151 1/27/04 Subramaniam 2/1; q,p. Changes of pneumoconiosis; em. Borderline cardiac enlargement with a tortuous aorta.
EX 15 01/27/04 Wheeler/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Minimal to moderate mixed linear-irregular and small nodular infiltrates or fibrosis in lateral periphery upper lobes with few tiny calcified granulomata compatible with TB unknown activity probably healed between anterior ribs 2-4 involving lateral pleura. Borderline enlargement left ventricle with CTR and minimal tortuousity descending thoracic aorta/check for hypertension and heart disease. Subtle thickening lower oblique fissure seen on lateral. Film quality 2—light.
EX 16 01/27/04 Scott/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Cardiomegaly with etr = 16.5/31.5. Peripheral

upper lung linear and nodular infiltrates and/or scarring extending to pleura and possibly containing calcified granulomata. Changes are probably due to TB, unknown activity. Film quality 1.

EX 17 01/27/04 Scatarige/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Peripheral reticulo-nodular upper and mid-lung infiltrates, probably increased since 1997. R/O active or reinfection TB vs. sarcoidosis. Cardiomegaly. Few calcified granulomata. Radiopaque pills in upper abdomen. Film quality 2—light—underexposure, slight sharpness.

DX 147 1/31/05 Bassali/BCR, B 2/2; r,u, 4 z,. Film quality 2.

CX 2 06/08/05 Alexander/BCR, B 2/1, q,r; ax, di, id. Lung volumes normal. Small primarily round opacities are present bilaterally, consistent with pneumoconiosis, category q,r, 2/1. Some "t" opacities present. Areas of coalescence are present in both upper zones. No large opacities are present. No chest wall pleural thickening or pleural calcifications are present. The costophrenic angles and the left diaphragm are clear. There is some interstitial prominence in the right lower zone which partially obscures the right diaphragm. The left hilum is slightly retracted (di), otherwise the cardiomediastinal structures and distribution of the pulmonary vasculature are normal. The bones are intact. Film quality 1.

EX 18 06/08/05 Wheeler/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Minimal to moderate mixed linear-irregular and small nodular infiltrates or fibrosis in lateral periphery upper lobes with few tiny calcified granulomata compatible with TB unknown activity probably healed between anterior ribs 2-4 involving lateral pleura and few tiny scars in lateral left apex. Few linear scars upper left lobe extending to left hilum compatible with healed pneumonia. Minimal tortuosity descending thoracic aorta and degenerative arthritis mid T-spine. Subtle thickening lower oblique fissure seen on lateral. No symmetrical small nodular infiltrates in central mid and upper lungs to suggest CWP. Also CWP does not involve pleura but an exact diagnosis is needed for any significant lung disease, usually by biopsy or microbiology. Film quality 1.

EX 19 06/08/05 Scott/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Peripheral fibrosis and/or infiltrates upper lungs extending to pleura. Probably TB,unknown activity. Film quality 1.

EX 20 06/08/05 Scatarige/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Nodular subpleural infiltrates in both upper lobes c/w TB, histo of uncertain activity. Other possibilities include sarcoid. Infiltrate anterior aspect RLL c/w pneumonia Need clinical correlation. No central small round opacities to suggest CWP/silicosis. Film quality1.

CX 1 01/03/06 DePonte/BCR, B 1/1; r,q; 4z; A. Film quality 1.

EX 44 01/03/06 Scott/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Peripheral upper lung infiltrates and/or fibrosis compatible with TB, unknown activity. Top normal heart size. Film quality 1.

EX45 01/03/06 Scatarige/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Linear and nodular subpleural opacities upper lobes, probably TB of uncertain activity—need clinical correlation. Calcified granuloma in LUL. Tortuosity of thoracic aorta. No small, central rounded opacities of CWP/silicosis. Film quality 1.

EX 46 01/03/06 Wheeler/BCR, B No parenchymal or pleural abnormalities consistent with pneumoconiosis. Coarse nodular infiltrate lateral periphery upper

lobes involving pleural compatible with granulomatous disease, histoplasmosis or TB. Minimal tortuousity descending thoracic aorta. Subtle degenerative arthritis T-spine. CTR 15.5/31. Film quality 1.

Pulmonary Function Studies

The record contains the following pulmonary function study evidence:

Ex. No.	Date	Age	Height	FEV1	MVV	FVC	FEV1/FVC%	Qualify?
DX 13	7/01/96	55	67"	3.39	109	3.79	89%	No.
DX 151	1/20/04	63	68"	2.68	---	3.63	74%	No.

Dr. Renn wrote a letter dated May 10, 2004 validating this pulmonary function study. (EX 2). He noted that the ventilatory function is normal.

Dr. Castle also wrote a letter dated May 12, 2004 pertaining to the pulmonary function study. (EX 25). He noted that the study was valid and demonstrates very mild, clinically insignificant airway obstruction.

* = Post-Bronchodilator

Arterial Blood Gas Studies

The record contains the following arterial blood gas study evidence:

Ex. No.	Date	pO2	PCO2	Qualify?
DX 10	07/08/96	80	38	No.
		*60	*38	Yes.

* = Post-Exercise

Medical Reports

Dr. A. Dahhan

Dr. Dahhan, who is board certified in internal medicine and pulmonary diseases, reviewed the miner's medical records and submitted a report dated January 9, 2006. (EX 34). Dr. Dahhan noted that Claimant worked in the mining industry as a driller and a shooter for 17 years, stopping in 1992 when he was laid off. He recorded that Claimant complained of shortness of breath on exertion, and suffers from cough, spasms, trouble sleeping, wheezes, and has chest pain.

Dr. Dahhan opined with a reasonable degree of medical certainty that: 1) Claimant has simple coal workers' pneumoconiosis; 2) Claimant has no complicated coal workers' pneumoconiosis based on the various radiological findings including the x-rays and CT of the chest; 3) From a functional respiratory standpoint, Claimant demonstrates no functional respiratory impairment or disability; 4) Based on the above, Claimant retains the physiological capacity to continue his previous coal mining work in a dust free environment or job of comparable physical demand; 5) Claimant has hypertension, a condition of the general public at large and is not caused by, related to, contributed to, or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

J. Randolph Forehand

Dr. Forehand, who is board certified in pediatrics, allergy and immunology, is a B reader, and was board eligible in pediatric pulmonary medicine at the time he examined Claimant on July 1, 1996, submitted a report on Form CM-988, which appears in the record at DX 14. Dr.

Forehand recorded that Claimant had 17 years of above ground coal mine employment and that he worked as a driller and blaster from 1985 to 1992. He noted that Claimant's family medical history is positive for high blood pressure in his uncle, heart disease in two aunts, diabetes in an uncle, cancer in his sister, and stroke in his father. He recorded Claimant's individual medical history as positive for attacks of wheezing in 1985, arthritis in 1989, heart disease in 1995, and high blood pressure in 1985. He also recorded that Claimant reported silicosis in 1986, and injury to his chest, right elbow, and both knees in a fall, and that he had eye surgery in 1982.

Dr. Forehand recorded that Claimant never smoked and that his chief complaints consist of daily sputum production, daily, exertional wheezing, daily, exertional dyspnea when walking and climbing, cough, chest pain--? angina, and 2 pillow orthopnea. Claimant's physical examination was essentially normal, and breath sounds on auscultation were of normal quality and distribution. Dr. Forehand performed objective studies that included a chest x-ray, pulmonary function study, arterial blood gas study, and an EKG. His cardiopulmonary diagnoses were: 1) Hypertension (RE, Hx); 2) Coal workers' pneumoconiosis (Hx, ABG)—silicosis. He noted that the etiology of the diagnoses was rock dust exposure of 17 years. Dr. Forehand opined that based on the arterial blood gas study, Claimant is totally and permanently disabled and would be unable to return to his last coal mining job and that silicosis is the sole contributing factor in the genesis of respiratory disability.

The record contains a letter from Dr. Forehand to the Claimant dated November 7, 1996. (DX 25). Dr. Forehand wrote that the spot on Claimant's lung first noticed during his black lung exam on July 1, 1996 has not changed in appearance or size on the more recent x-ray of November 4, 1996. He stated that the finding most likely stems from Claimant's exposure to coal dust.

The record contains another letter from Dr. Forehand to the Stone Mountain Health Clinic dated April 8, 2000. (DX 80, 151). Dr. Forehand wrote that he has cared for Claimant for three years and that Claimant has a well documented case of coal workers' pneumoconiosis. He notes that Claimant worked for 17 years as a driller and blaster and that the job generates a mixture of hard rock dusts which places the employee at risk of developing occupational lung disease. He stated that Claimant's chest x-ray has been abnormal for a number of years with coal workers' pneumoconiosis/silicosis. Dr. Forehand wrote that Claimant's disabling lung disease arose from his employment as a driller/blaster and the striking appearance of the chest x-ray and exercise induced hypoxemia are characteristic of CWP. He noted that Claimant did not smoke cigarettes and has no history of asthma, further confirming CWP as the principle cause of his lung disease. Dr. Forehand wrote that Claimant may require oxygen therapy in the future and he is totally and permanently disabled.

The record contains a letter to Claimant's attorney dated July 19, 2001 from Dr. Forehand. (DX 107). Dr. Forehand wrote that Claimant is a disabled coal miner who worked as a surface mine hard-rock driller and who now has radiographic evidence of coal workers' pneumoconiosis. He stated that this happened because: 1) Hard rock drilling generates high levels of hard rock dust; 2) Claimant was not provided protective cab or other means to prevent exposure to hard rock dust generated as a surface mine driller. Dr. Forehand stated that due to Claimant's lung injury, Claimant would be unable to return to his last job as a hard rock driller without significantly jeopardizing his already impaired respiratory health and because of Claimant's health, no coal company would be willing to hire him to perform his previous job or similar jobs in surface or underground coal mining.

José M. Piriz

The record contains a letter from Dr. Piriz of Clinch Valley Physicians. (DX 141). Dr. Piriz writes that Claimant was seen for an evaluation of chest discomfort in 1997 and that workup included an echo and stress test which demonstrated "at high-risk stress scan." He explained that stress test with nuclear imaging is approximately 90-92% accurate for determination of ischemia or lack of blood flow, but at this point, he cannot say with 100% certainty that there is coronary artery disease. Dr. Piriz stated that he discussed cardiac catheterization with Claimant in order to be 100% certain of his underlying coronary anatomy but that Claimant declined. Dr. Piriz stated that at this point he cannot be 100% certain that Claimant does not have coronary artery disease without performing further investigations, including but not limited to cardiac catheterization.

Dr. Vishnu A. Patel

The record contains a letter from Dr. Patel, Claimant's treating physician, dated April 15, 2002. (DX 151). He wrote that Claimant carries the diagnosis of complicated pneumoconiosis as evidenced on a CT scan of the chest which was recently repeated showing no change. He noted that Claimant does continue to suffer with significant dyspnea on minimal exertion and requiring daily use of respiratory medications.

Samuel V. Spagnolo

Dr. Spagnolo reviewed the miner's medical records and submitted a supplemental report dated January 21, 2006. He is board certified in internal medicine and pulmonary diseases, and this report appears in the record at EX 35. He noted that Claimant worked in the mines from 1975 through 1992 and retired when the mine closed. Dr. Spagnolo recorded Claimant's job as a driller, which required carrying and lifting heavy objects weighing 55-60 pounds. He noted that Claimant never smoked cigarettes and wore a respirator whenever he could.

Dr. Spagnolo opined within a reasonable degree of medical certainty that Claimant appears to have had sufficient exposure to coalmine dust to result in pneumoconiosis. He opined after reviewing all the available information in the case, including the additional supplemental evidence, his earlier opinion in this case is not changed. Dr. Spagnolo stated that he places the greatest weight on the opinion reports and interpretations of Drs. Wheeler, Scatarige, and Scott because they are preeminent radiologists. He noted that their reports note radiologic changes of prior granulomatous disease such as TB, histoplasmosis, and sarcoid and explained that a negative TB finding would not be against the presence of inactive TB since skin test reactivity tends to wane over time. Dr. Spagnolo stated that Claimant's spirometry values have remained consistently within normal limits and do not support the presence of any lung disease that would prevent him from performing his prior coal mine work. He explained that Claimant has well documented cardiac disease unrelated to his coal mine employment and his cardiac dysfunction is sufficient to explain his respiratory complaints and progressive shortness of breath. Dr. Spagnolo stated that his opinion of the degree and cause of any respiratory disability would not change if Claimant were found to have CWP.

Dr. James R. Castle

Dr. Castle reviewed additional medical information and submitted a report dated January 26, 2006. (EX 36). He opined within a reasonable degree of medical certainty that Claimant does have radiographic evidence of simple coal workers' pneumoconiosis and also opined within

a reasonable degree of medical certainty that Claimant most likely does not suffer from complicated coal workers' pneumoconiosis. He noted that Claimant worked in or around underground mining long enough to have developed coal workers' pneumoconiosis if he were a susceptible host, worked in surface mining for approximately 17 years as a driller/shooter, and was a lifelong nonsmoker.

Dr. Castle stated that Claimant's cardiac disease is another risk factor for development of pulmonary symptoms and has evidence of atherosclerotic cardiovascular disease and hypertensive cardiovascular disease with reduced left ventricular function. He explained that both conditions can result in significant shortness of breath and the miner has had a cerebrovascular accident as a result of his very severe generally poorly controlled hypertension. Dr. Castle stated that at no time did Claimant demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process and did not have the consistent finding of rales, crackles, or crepitations and on most occasions, his chest examination was normal.

Dr. Castle stated that it is his opinion that he did have radiographic findings consistent with simple coal workers' pneumoconiosis and did not have evidence of complicated coal workers' pneumoconiosis. He noted that most CT evaluations did not indicate complicated pneumoconiosis, although some CT scan studies indicated to some radiologists that he might. Dr. Castle explained that none of the valid physiologic studies demonstrated a disabling respiratory impairment from any cause and most of the valid studies were entirely normal, showing no evidence of obstruction or restriction. He noted that on some occasions, Claimant did demonstrate a very minimal, clinically insignificant degree of airway obstruction that was nondisabling.

Dr. Castle noted that all of the arterial blood gas studies were entirely normal except one that was obtained years ago and the abnormality could not have been due to coal workers' pneumoconiosis because when coal workers' pneumoconiosis causes hypoxemia, it is permanent and does not revert or become normal with time. Dr. Castle opined, with a reasonable degree of medical certainty that from a pulmonary point of view, Claimant does retain the respiratory capacity to perform his previous coal mine employment duties and he is not permanently and totally disabled as a result of any pulmonary process including coal mine dust induced lung disease. He opined that Claimant is very likely permanently and totally disabled as a result of multiple medical problems including coronary artery disease, hypertensive cardiovascular disease, hypertension, diabetes, and renal insufficiency. Dr. Castle explained that these are all conditions of the general public at large and are unrelated to the inhalation of coal mine dust and coal workers' pneumoconiosis.

Dr. Castle testified in a deposition on March 10, 2006. The deposition transcript appears in the record at EX 48. Dr. Castle described the medical and legal coal workers' pneumoconiosis and agreed that coal workers' pneumoconiosis can be progressive. EX 48 at p. 7. Dr. Castle testified that dyspnea is not diagnostic of any lung disease and could be related to other organ systems such as the cardiac system, or obesity, neuromuscular disorders, or endocrine abnormalities. EX 48 at p. 11. He testified that wheezing is a finding or sign of generally some type of airway obstruction. *Id.* Dr. Castle explained that pulmonary edema fluid gets into the alveolar spaces in the lung and results in a very acute severe problem with sudden onset of shortness of breath, profuse sweating, tachycardia, and fall in oxygen tension related to the fluid coming out into the lungs. EX 48 at p. 14. He explained that a cerebral hemorrhage means that there has been a broken or ruptured blood vessel in the brain, is a form of stroke, is considered to

be a hemorrhagic stroke that can be anything from fatal to minimal but is usually a result of either atherosclerosis or hypertensive vascular disease and he would attribute this in Claimant's case to his systemic hypertension. *Id.*

Dr. Castle described sleep apnea as a condition resulting in disordered breathing at night, whereby the muscles in the pharynx relax, allowing the pharynx to fall back and obstruct just behind the tongue and that results in the inability of the person to breathe in air while they are sleeping and it is also associated with hypertension. EX 48 at 15. Dr. Castle testified that he interpreted two of Claimant's chest x-rays as 1/1 with r and t type opacities in all lung zones and the second film had axillary coalescence. EX 48 at p. 17. He testified that the films were consistent with simple coal workers' pneumoconiosis, did not note any progression in the four years between the x-rays, and did not see any evidence of large opacities. EX 48 at pp. 17-18. Dr. Castle explained that axillary coalescence is the finding of superimposed nodules or opacities on a chest x-ray and that the nodules/opacities maintain a distinctness and identity. EX 48 at p. 18. He further explained that axillary coalescence differs from complicated pneumoconiosis because complicated disease is a lesion one centimeter or greater and you don't distinguish or see specific opacities in that. *Id.*

Dr. Castle stated that a granuloma is a scar typically related to certain types of infections. EX 48 at p. 19. He testified that it is possible Claimant could have histoplasmosis without knowing it and people that have it may have minimal or no symptoms at all. EX 48 at p. 20. Dr. Castle testified that it is possible a person can get TB and not know it and the germ becomes dormant in the body. EX 48 p. 21. He explained that many people are infected with atypical or noncontagious TB but don't have active disease and that a TB skin test is not likely to be useful in the noncontagious form of atypical tuberculosis. EX 48 at pp. 21-22. Dr. Castle testified that based on the objective studies that he reviewed, Claimant does not have a totally disabling pulmonary or respiratory impairment. EX 48 at p. 25. He stated that it is possible that Claimant could have normal studies with Category A complicated pneumoconiosis, but not with Category B or C, and he would expect that his PFT's would be abnormal with Category A because people with Category A disease have a very high degree of profusion and have abnormal studies. *Id.* He testified that he believes Claimant has the respiratory capacity to perform his last coal mine employment and that he doesn't see that there has been any development of respiratory impairment at all. *Id.* Dr. Castle testified that he believes Claimant is disabled as a result of hypertension and hypertensive cardiovascular disease and very likely as a result of coronary artery disease. EX 48 at p. 36.

Dr. Castle explained that when determining profusion, one doesn't look at just the spot of coalescence but looks at everything else in that lobe or zone and then everything gets averaged out. EX 48 at pp. 29-30. He further explained that the coalescence and profusions are based upon the ILO film standards. EX 48 at p. 32. Dr. Castle testified that one can see complicated pneumoconiosis with 1/1 profusion and one would not necessarily see impairment with Category A complicated pneumoconiosis. EX 48 at p. 34. He explained that one would expect to see impairment or abnormalities with a profusion of 3/3 or 3/2. EX 48 at p. 35.

Dr. Lawrence Repsher

Dr. Repsher examined Claimant on June 8, 2005 and his report appears in the record at DX 168. He is board certified in internal medicine, pulmonary disease, and critical care medicine and is a B-reader. Dr. Repsher noted that Claimant reported 17 years of coal mine employment but that records indicate only nine years. He noted that Claimant last worked as a

rock driller and used only dry drills, and retired in September 1995 when the mine closed. Dr. Repsher noted that Claimant complains of progressive shortness of breath for several years and nonproductive cough, and denied chills, fevers, or sweats. He noted that Claimant also denied chest pain, hemoptysis, orthopnea, or PND but does have ankle edema. Dr. Rephser noted that Claimant denied a prior history of asthma, SAR, or TB and a remote TB skin test was negative. Dr. Repsher recorded that Claimant never smoked cigarettes and is not aware of his family medical history. He noted Claimant has been diagnosed with diabetes mellitus and coronary artery disease.

Dr. Repsher performed a physical examination that was essentially normal and examination of the chest revealed normal breath sounds, with no rales or wheezes even with forced expiration. Dr. Repsher performed objective studies that included a chest x-ray, pulmonary function study, an arterial blood gas study, and an EKG. A CT scan was ordered but not taken. Dr. Repsher noted that he provided earlier medical reports on April 29, 1997 and January 29, 2001 and noted that his findings were suggestive of possible simple coal workers' pneumoconiosis with normal pulmonary function, ischemic and hypertensive cardiomyopathies, non-insulent dependent diabetes mellitus, osteoarthritis, a stable mediastinal mass noted on CT scan and chronic depression with anxiety.

Dr. Repsher's current impression is: 1) Possible evidence of simple coal workers' pneumoconiosis; 2) No evidence of any pulmonary or respiratory impairment or disability either caused by or aggravated by his employment as a coal miner with exposure to coal mine dust; 3) Severe coronary artery disease, complicated by ischemic cardiomyopathy; 4) Severe hypertension, complicated by HCVD with probably diastolic dysfunction; 5) Noninsulin dependent diabetes mellitus, complicated by probably K-W disease; 6) Moderate chronic renal failaure; 7) History of stable mediastinal mass; 8) Osteoarthritis; 9) Chronic depression with anxiety.

Dr. Repsher opined that although Claimant may have radiographic evidence of simple CWP, he is not now and never has suffered from any pulmonary impairment or disability, either caused by or aggravated by his employment with Employer with the inhalation of coal mine dust. He stated that his reasons for this opinion are: 1) Although he has possible radiographic evidence of CWP, there is no associated pulmonary or respiratory impairment. It is very clear from the medical literature that coal miner's with 0/0 to 3/3 radiographic simple CWP, on the average, have normal lung function; 2) He has no histologic evidence of CWP. There are no lung biopsy slides for review; 3) He has no PFT evidence of CWP and his PFTs are within normal limits, when adjusted for effort and cooperation; 4) He has no ABG evidence of CWP. His ABGs show a mild non-qualifying hyoxemia; 5) He is suffering from a number of other serious and potentially serious diseases and conditions. However, none of these could be fairly attributed to his work as a coal miner with exposure to coal mine dust. Rather, these are diseases and conditions of the general population, which are primarily related to heredity and lifestyle factors; 6) His respiratory symptoms are more than adequately accounted for by his severe underlying ischemic and hypertensive cardiomyopathies.

Dr. Repsher testified in a deposition on March 9, 2006. The deposition transcript appears in the record at EX 47. Dr. Repsher described the medical and legal coal workers' pneumoconiosis and stated that although it is uncommon, coal workers' pneumoconiosis can be progressive. EX 47 at pp. 7-8. Dr. Repsher testified that shortness of breath in a 64 year old man is consistent, by a factor of 20 to one, with heart disease and not lung disease. EX 47 at p. 14. He explained that Claimant has a long history of very severe cardiac problems, has three-

vessel heart disease, arteriosclerotic heart disease, and also has severe hypertension with hypertensive cardiovascular disease. EX 47 at p. 17. Dr. Repsher explained that pulmonary edema is the result of a failing left ventricle, and an accumulation of fluid in the lungs and these types of cardiac problems would result in symptoms of shortness of breath with heart disease and not lung disease. EX 47 at p. 14. He explained that Claimant has a long history of very severe cardiac problems, has three-vessel heart disease, arteriosclerotic heart disease, and also has severe hypertension with hypertensive cardiovascular disease. EX 47 at p. 17. Dr. Repsher explained that pulmonary edema is the result of a failing left ventricle, and an accumulation of fluid in the lungs and these types of cardiac problems would result in symptoms of shortness of breath with exertion and possibly at rest. EX 47 at p. 18. He further explained that pulmonary edema would cause shortness of breath at rest and would also be associated with symptoms of orthopnea, PND, and often associated ankle swelling or ankle edema. *Id.*

Dr. Repsher explained that intracerebral hemorrhage is bleeding into the brain tissue and is generally the result of inadequately treated hypertension. EX 47 at p. 19. He explained that there are two types of sleep apnea, that central sleep apnea is due to a problem with the respiratory drive center and obstructive sleep apnea, which refers to the upper airways obstruction due to redundant tissue in people who are markedly overweight. *Id.* Dr. Repsher testified that Claimant's chest x-ray showed bilateral fibronodular disease but it was an atypical pattern so he felt it was a result of some other cause such as tuberculosis. EX 47 at p. 22. He explained that with coal workers' pneumoconiosis, he would expect to find bilateral, mostly upper lobe, rounded opacities and Claimant had both rounded and linear opacities in all lung zones. EX 47 at p. 23. He testified that he cannot rule out simple coal workers' pneumoconiosis but he can rule out complicated coal workers' pneumoconiosis. EX 47 at p. 24.

Dr. Repsher explained that granulomas are usually due to infection with fungi or tuberculosis or other conditions such as sarcoidosis. EX 47 at p. 25. He explained that histoplasmosis results from infection with histoplasma capsulatum, which is a fungus ubiquitous in the Appalachian environment. EX 47 at p. 26. Dr. Repsher testified that the standard PPD test for tuberculosis is not that sensitive and can have false negatives. *Id.* He explained that with Category A, complicated pneumoconiosis, one would expect spirometry values to be normal, Category B is frequently normal but can be abnormal, and Category C is generally abnormal. EX 47 at p. 29.

Dr. Repsher testified that he believes Claimant's lung function is entirely normal. EX 47 at p. 33. Dr. Repsher testified that even if Claimant's entire employment involved heavy labor, he would have the respiratory capacity to perform it. EX 47 at p. 36.

Dr. Kathleen A. DePonte

Dr. DePonte testified in a deposition on May 12, 2006. (CX 3). Dr. DePonte is a board certified radiologist and B reader. CX 3 at p. 4. Dr. DePonte testified that her interpretation of Claimant's January 3, 2006 chest x-ray was small opacities, type r/q that were present in the mid and upper lung zones bilaterally, with profusion 1/1 and large opacity, Category A was noted. CX 3 at p. 5. She testified that no pleural abnormalities consistent with pneumoconiosis were noted, coalescence was present, and pneumoconiosis was with early progressive massive fibrosis. CX 3 at pp. 5-6. Dr. DePonte testified that the coalescence of smaller rounded opacities were in the upper lung zones, just below the apicies. CX 3 at p. 6. She explained that she believes there is a large opacity which measures just over ten millimeters and qualifies as a type A opacity located on the left, overlying the anterior into the left fourth rib. *Id.*

Dr. DePonte explained that in order to distinguish the opacity from tuberculosis, one looks at the underlying pattern of opacities and TB typically tends to be more superior involving the upper portions of lung apicies, where in Claimant's case, the rounded opacities and the coalescence occurred over the second and third ribs bilaterally and down near the fourth rib on the left. CX 3 at p. 7. She further explained that most of the time, TB is not symmetric and usually doesn't involve bilateral symmetry, unless it is miliary TB, which is blood borne. CX 3 at p. 8. Dr. DePonte testified that another way to rule out TB is to look at the stability of this over a period of time. *Id.* She testified that opacities caused by rheumatoid arthritis tend to be larger, rounded, and occur more in the lower lungs and other granulosa don't look like this. *Id.* She explained that histoplasmosis typically present as well defined, small, rounded, densely calcified granulosa but you don't get the fibrosis from the coalescence seen here. CX 3 at pp. 8-9.

Dr. DePonte testified that the miner's x-ray is a fairly close classic presentation of complicated coal workers' pneumoconiosis. CX 3 at p. 9. She stated that in her opinion, Claimant really does have pneumoconiosis and [it] doesn't fit the pattern of some of the other diseases and that she discussed. CX 3 at p. 10. She further stated that she thinks pneumoconiosis is by far the etiology of Claimant's pulmonary abnormalities. *Id.* Dr. DePonte testified that in her opinion, by the presence of what appears to be a large opacity over the anterior left fourth rib, Claimant would meet the criteria of complicated pneumoconiosis. *Id.*

Dr. DePonte testified that it is not important for her to know when doing a B reading the amount of coal dust exposure a miner has had because she is really just looking at the radiographic findings and that it is immaterial to her to know what was the miner's last year of the miner's exposure to coal dust. CX 3 at p. 12. Dr. DePonte testified that it is only in the cases in which the findings don't fit or don't quite make sense that it's more important to look at a sequential series of x-rays. CX 3 at p. 14.

"Other" Medical Evidence

CT Scan Evidence

Dr. Kevin Legendre performed a CT scan of Claimant's chest on November 7, 1996. (DX 69, 47). His impression was: 1) Anterior mediastinal mass consistent with possible adenopathy, thymic tumor, teratoma, or possible substernal thyroid; 2) Extensive interstitial changes in patient with reported history of pneumoconiosis. Small nodular densities may represent focal areas of scarring however a more aggressive process cannot be excluded.

Dr. George A. Crawford reviewed Claimant's CT scan of the chest taken on November 7, 1996. (DX 70). His impression was: 1) There appears to be granulomatous scarring in the lungs with interstitial and parenchymal components; 2) There are multiple small nodules throughout the lungs varying between 4 and 10 mm. in size.

Dr. Crawford performed another CT scan of Claimant's chest on January 12, 1998 after Claimant was referred by Dr. Forehand for chest pain and shortness of breath. (DX 71). His impression was: 1) There appears to be diffuse granulomatous scarring in the lungs with interstitial and parenchymal components; 2) There appears to be some areas of conglomerate scarring in the mid lung fields, particularly on the left side. There also appear to be areas of pleural reaction along the lateral posterior chest walls; 3) There appear to be multiple small nodules throughout the lungs varying between approximately 5 and 10 mm. in size. These were described in a report evaluating an outside CT study on 12/19/97. However, the comparison films were not available for comparison at this time.

Dr. Maurice Bassali reviewed Claimant's CT scan of the chest taken on January 12, 1998. (DX 72). His impression was: 1) Severe diffuse chronic interstitial lung disease seen consistent with complicated coal workers' pneumoconiosis category A, superimposed upon pneumoconiosis type r/u, profusion 3/3, affecting all six lung zones; 2) Bilateral wall pleural plaques are seen in the upper chest, as described; 3) The association of the above findings with history of exposure to coal dust during work is diagnostic of coal workers' pneumoconiosis, as above described; 4) There is progression of pneumoconiosis since previous studies of 1986, as well as 1995.

Dr, Navani reviewed Claimant's CT scan of the chest taken on January 12, 1998 and completed an ILO classification form in connection with the CT scan. (DX 73). Dr. Navani wrote, "2/2; A—left upper zone. ax.

Dr. Jon C. Scatarige reviewed Claimant's CT scan of the chest taken on November 2, 2000. (EX 27). His findings were: 1) No small, central, round opacities to suggest CWP or silicosis. No pleural plaques are identified; 2) Reticular and nodular opacities in periphery of upper and mid lung zones, some extending from hila to pleura. DDX: TB of uncertain activity, non-tuberculous mycobacterial infection, or sarcoidosis; 3) Calcified right paratracheal and subcarinal lymph nodes, compatible with healed granulomatous disease; 4) Minimal scarring in RML; 5) Minimal dilatation of ascending aorta (4 cm).

Dr. Scatarige also was given an MRI of the thorax dated May 29, 2001. He explained that he does not have sufficient training and experience in MRI to submit an interpretation and stated that in general, MRI has no significant role to play in the evaluation of lung parenchyma for pneumoconiosis and conventional CT and high-resolution CT are much more useful in this regard.

Claimant underwent a CT scan on August 19, 2004 that was interpreted by Dr. Stephen Raskin. (DX 151). His findings were: 1) Coarse, reticular interstitial lung disease; 2) Complicated CWP with bilateral progressive massive fibrosis; 3) No additional lesions.

Dr. Scatarige interpreted Claimant's CT scan of the chest taken on August 19, 2004. (EX 42). His findings were: 1) No small, rounded opacities to suggest CWP or silicosis. No pleural plaques are identified; 2) Nodular and reticular infiltrates/fibrosis in periphery of each upper and mid-lung that extend to the pleura. Few small right paratracheal and subcarinal lymph nodes. Differential diagnosis includes TB, histoplasmosis, and sarcoidosis. Advise clinical correlation with sputum culture and consider transbrachial biopsy to establish a definitive diagnosis; 3) 6 mm nodule in peripheral RML—possibly a granuloma. Advise follow-up CT in 6-12 months; 4) Minimal interstitial infiltrates/fibrosis in RLL; 5) Thickened septal and lateral walls of the left ventricle—the findings are compatible with left ventricular hypertrophy. Clinical correlation is needed; 6) Thickened wall of distal thoracic esophagous, compatible with chronic reflux esophagitis.

Dr. Wheeler interpreted Claimant's CT scan of the chest taken August 19, 2004. (EX 43). He noted small, irregular mass in lateral RUL and LUL involving pleura and small nodules in lateral pleura LUL more than RUL compatible with granulomatous disease, histoplasmosis or TB. An exact diagnosis is needed for any significant lung disease to assure proper therapy. Few linear scars in posterior lower medial RLL near T-spine. Poor quality coronal reconstructions. No symmetrical, small nodular infiltrates in central and mid and upper lungs.

Claimant underwent another CT scan of the chest on February 2, 2005 that was interpreted by Dr. David L. Groten. (DX 151). His impression was: Findings most likely reflecting complicated pneumoconiosis are identified. Comparison with the previous examination, when available, would be helpful.

Dr. Scatartige interpreted Claimant's CT scan of the chest taken on February 2, 2005. He found: 1) Peripheral mass-like infiltrates in both upper lobes, 2cm in LUL, extending to the pleural surfaces and with a small sub-pleural bleb on Right. Many small, non-calcified round opacities in the lateral 1/3 of each lung, with relative sparing of the central portion of the upper and mid lung zones. There are calcified right paratracheal and sub-carinal lymph nodes. Sparing of the central lungs and pleural extension is not typical of silicosis or CWP. I favor TB, histoplasmosis, non-TB mycobacterial infection, and, less, likely, lung metastases. Advise clinical correlation and CT follow-up in 6 months and also consider a tissue diagnosis; 2) Minimal subpleural fibrosis in LLL and RML. Calcified granulomata in LLL and RML; 3) Mosaic pattern with increased lung density in the RLL, associated with slightly increased diameter of RLL vessels. Findings likely due to lung perfusion differences; 4) Minimal calcification left coronary artery: suggest clinical correlation for angina pectoris.

Claimant underwent another CT scan of the chest on April 1, 2005 that was interpreted by Dr. Daniel J. Fowler. (DX 151). His impression was: 1) Fairly diffuse reticulonodular scarring, larger irregular densities in both upper lobes, and COPD in the lungs, all stable and unchanged from 2/02/05 compatible with benign complicated pneumoconiosis; 2) A follow-up CT scan of the chest in six months may be useful to evaluate for continued stability.

Dr. Scatarige reviewed another CT scan of the chest taken on April 1, 2005 and compared it to the February 2, 2005 CT scan. His findings were: 1) Unchanged since last examination; 2) Peripheral mass-like infiltrates in both upper lobes, 2 cm LUL, extending to the pleura and with small sub-pleural bleb on right side. Many small, non-calcified round opacities in the lateral 1/3 of each lung, with relative sparing of the central portion of the upper and mid lung zones. There are 1.5 cm right paratracheal and sub-carinal lymph nodes. Sparing of the central lungs and pleural extension is not typical of silicosis or CWP. I favor TB, histoplasmosis, non-TB mycobacterial infection. The lack of change in 2 months makes metastasis less likely. Advise clinical correlation and CT follow-up in 6-12 months. Also, consider obtaining a definitive tissue diagnosis via bronchoscopy; 3) Minimal subpleural fibrosis in LLL and RML. Calcified granulomata in LLL and RML; 4) Mosaic pattern with increased lung density in the RLL, associated with slightly increased diameter of RLL vessels. Findings likely due to lung perfusion differences; 5) Minimal calcification proximal left coronary artery; 6) 1 cm exophytic nodule left kidney, probably small cyst.

Dr. Lawrence A. Repsher reviewed the February 2, 2005 and April 1, 2005 CT scans and submitted a letter which appears at EX 26. Dr. Repsher advised that the scans were only in mediastinal windows and there were no parenchymal windows, which are necessary to evaluate for small opacities; thus, the films were not helpful in determining whether the miner has radiographic simple coal workers' pneumoconiosis.

MRI Evidence

Claimant had an MRI of the chest on May 29, 2001. (DX 147). It was interpreted by M. Shahan, M.D. The impression was: 1) Known pneumoconiosis; 2) No suspicious masses. No right heart or pulmonary abnormality seen.

Hospitalization Records and Treatment Notes

The record contains a cardiac stress test report with arterial blood gas analysis interpreted by Dr. J. Randolph Forehand and dated July 27, 1997. (EX 41). Dr. Forehand's impression was normal cardiac stress test; exercise induced fall in oxygen tension; hypertension.

The record contains the progress reports and treatment notes of Dr. Jon D. Cargo of the Carilion Medical Associates. (EX 1). The first note is a letter to Claimant from Dr. Cargo dated June 5, 2002 in which Dr. Cargo informs Claimant that he is unable to continue as his physician due to his disruptive and offensive behavior toward his office staff. The record contains a progress note dated May 30, 2002 that indicates that Claimant presented to the office with no new complaints but that he has chronic complaints and uncontrolled hypertension. Claimant was also seen in the office on April 19, 2002 complaining of being full of fluid and swelling of his legs. The note indicates that Claimant also complained of shortness of breath at times, edema, and weight gain. On physical examination, his heart rate revealed a regular rate and rhythm, the lungs were clear, and the extremities revealed 2+ pitting edema of the lower extremities. Claimant was advised to stop Minoxidil as it was increasing his swelling and was advised as to his other medications. Claimant was also seen in the office on March 19, 2002 for congestion and a nonproductive cough, and he complained of wheezing and some shortness of breath. The physical examination described an "alert, cooperative African-American female", the lungs revealed some diffuse expiratory wheezes, and the heart rate and rhythm were without murmur, rub, or gallop. Dr. Cargo diagnosed benign, essential hypertension unchanged and acute bronchitis.

The record contains reports from Duke University Medical Center. (DX 141, 151). A chest x-ray report taken on November 11, 2002 indicates that: "Parenchymal lung disease may represent sarcoidosis, pneumoconiosis could have a similar radiographic appearance."

Claimant was seen by Victor Tapson, M.D. in the Pulmonary Hypertension Clinic for further evaluation of possible pulmonary hypertension. Dr. Tapson's assessment was that Claimant appears to have pneumoconiosis which has apparently resulted in variable pulmonary function testing results, he does not have pulmonary hypertension based on echocardiography and fortunately does not [illegible] significantly. He noted that it may be prudent to consider right and left heart catheterization if the cardiac disease is to be explored further. Dr. Tapson noted that Claimant already had an intercerebral hemorrhage in the past and has a family history of stroke. He stated that his blood pressure needs to be controlled, and Claimant needs a formal exercise test.

A pulmonary function study performed on November 10, 2002 at Duke University revealed and FEV 1 of 2.65, FVC of 3.72 and an MVV of 85. The FEV1/FVC was 71%. Claimant's age and height are not noted on the record and there are no accompanying tracings. An arterial blood gas study on the same day showed a PO2 of 95 with a PCO2 of 38. This study is non-qualifying.

CONCLUSIONS OF LAW

Length of Coal Mine Employment

Claimant was a miner within the meaning of the Act for 11.75 years. Based on review of the evidentiary record, the Miner's Social Security records and the Employer's employment record for the Miner indicate that Judge Levin and Judge Miller correctly determined that the

Claimant completed eleven and three-quarters years of coal mine employment between April 28, 1975 and February 15, 1992 (DX 4, DX 6).

Date of Filing

I find that Claimant filed his claim for benefits under the Act on April 19, 1996. (DX 1).

Responsible Operator

Employer does not contest that it is the responsible operator. Tr. 11. Accordingly, I find that Consolidation Coal Company is the responsible operator and will provide payment of any benefits awarded to Claimant.

Dependents

The Employer previously agreed that the miner has two dependants. DX 175. However, Claimant's wife is deceased. (DX 163). In addition, Claimant previously established that he has one dependent, his daughter, who was born in September 1983. However, his daughter would now be 23 years old, and there is no evidence in the record that she is still attending school. Accordingly, I find that Claimant does not have any dependents for purposes of augmentation of benefits.

Standard of Review

I need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his/her own conclusions and inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 B.L.R. 1-190 (1989); *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986); *Todd Shipyards Corp. v. Donovan*, 300 F.2d 741 (5th Cir. 1962). The adjudicator's function is to resolve the conflicts in the medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Lafferty, supra*; *Fagg v. Amax Coal Co.*, 12 B.L.R. 1-77 (1988); *aff'd*, 865 f.2d 916 (7th Cir. 1989); *Short v. Westmoreland Coal Co.*, 10 B.L.R. 1-127 (1987); *Piccin v. Director, OWCP*, 6 B.L.R. 1-616 (1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 B.L.R. 2-84 (7th Cir. 1983).

In considering the medical evidence of record, I must not selectively analyze the evidence. *See Wright v. Director, OWCP*, 7 B.L.R. 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Crider v. Dean Jones Coal Co.*, 6 B.L.R. 1-606 (1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 B.L.R. 2-84 (7th Cir. 1983); *see also Stevenson v. Windsor Power House Coal Co.*, 6 B.L.R. 1-1315 (1984). The weight of the evidence, and determinations concerning credibility of medical experts and witnesses, however, is for the administrative law judge to determine. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Brown v. Director, OWCP*, 7 B.L.R. 1-730 (1985); *see also Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Henning v. Peabody Coal Co.*, 7 B.L.R. 1-753 (1985); *Peabody Coal Co. v. Benefits Review Board*, 560 F.2d 797, 1 B.L.R. 2-133 (7th Cir. 1977).

As the trier-of-fact, I have broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v. Director, OWCP*, 7 B.L.R. 1-167 (1984). In considering the evidence on any particular issue, the administrative law judge must be cognizant of which party bears the burden of proof. Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. *See White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

The Existence of Pneumoconiosis

In his July 9, 2002 Decision and Order, Judge Miller found, as did Judge Levin before him, that Claimant established the existence of pneumoconiosis due to his coal mine employment but did not establish the existence of complicated pneumoconiosis. This decision was subsequently affirmed by the Benefits Review Board. As previously discussed, in evaluating a request for modification, I am required to conduct a *de novo* review of the record and to determine whether there was a mistake in a determination of fact.

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods: (1) a chest x-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by reasoned medical opinion. 20 C.F.R. § 718.202(a).

Additionally, the Fourth Circuit Court of Appeals held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffers from coal workers' pneumoconiosis. *Island Creek Coal Co. v. Compton* 211 F.3d 203 (4th Cir. 2000).

Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. *Clark v. Karst-;Robbins Coal Co*., 12 B.L.R. 1-;149 (1989)(en banc); *Casella v. Kaiser Steel Corp*., 9 B.L.R. 1-131 (1986). This rule should not be mechanistically applied, however, in situations where the evidence would tend to demonstrate an 'improvement' in the miner's condition. This is because the Board and courts agree that pneumoconiosis is progressive and irreversible.

Reviewing all of the relevant medical evidence, including the newly submitted evidence, I find that Claimant has demonstrated the presence of coal workers' pneumoconiosis. The majority of the medical experts, including Employer's experts Drs. Castle, Repsher,[3] and Spagnolo, agree that Claimant has demonstrated the presence of simple coal workers' pneumoconiosis through x-ray. None of these gentlemen are dually qualified x-ray readers, however. The x-ray evidence is in conflict, but I accept that it establishes pneumoconiosis.

Where two or more x-ray reports are in conflict, the radiographic qualifications of the physicians interpreting the x-rays must be considered. 20 C.F.R. § 718.201(a)(1). The interpretations of physicians who are dually-qualified (board-certified radiologists and B-readers) are entitled to the greatest weight. The Benefits Review Board held that it is proper to credit the interpretation of a dually-qualified physician over the interpretation of a B-reader. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999)(en banc on recon.).

Of those who read the more recent x-rays, those submitted after Judge Miller's decision, Drs. DePonte, Alexander, Bassali, Wheeler, Scott and Scaterige are all dually qualified board certified radiologist B readers. For reasons more fully set forth at length below, in the discussion of complicated pneumoconiosis, although they are well qualified readers, I attribute less weight to the opinions of Drs. Scott, Wheeler and Scaterige, because they render less than unequivocal

[3] See EX 26. However, in his deposition, Dr. Repsher noted that although he marked the June 8, 2005 x-ray as 1,2, he testified that it was TB. EX 47 at 21-23. He later had to admit that he filled in the form as 1,2. Id, 42. I find that the form is positive.

opinions that although the x-rays are positive, they are positive for tuberculosis, rather than pneumoconiosis.

The new evidence consists of 18 readings of five x-rays. Six of the 18 are positive for the existence of pneumoconiosis. I note that more than six months had elapsed after the June, 2005, x-ray, which I note is a sufficient time period to trigger an emphasis on the most recent evidence. The only x-ray reading that is uncontroverted is the January 31 2005 reading by Dr. Bassali, which is positive (2,2), (but which does not note complicated pneumoconiosis). DX 147. The Employer submitted three readings from experts to counter many of the new x-rays. Only CX 1 is read as complicated pneumoconiosis by Dr. DePonte, Claimant's expert.

As I attribute less weight to the opinions of Drs. Scott, Scaterige and Wheeler, who rendered all 12 of the readings of the five new x-rays, attributing TB as the probable diagnosis, the remaining x-ray readings are all positive. I give more weight to the opinion rendered by Dr. DePonte, who in explaining why the reading establishes pneumoconiosis also explained why the diagnosis could not be TB. CX 3. See below.

I also note that there is a distinction between clinical and legal pneumoconiosis. "Legal pneumoconiosis is a much broader category of disease" than medical pneumoconiosis, which is "a particular disease of the lung generally characterized by certain opacities appearing on a chest x-ray." *Island Creek Coal Co. v. Compton*, supra at 210. The burden is on the Claimant to prove that his coal-mine employment caused his lung disease. 20 C.F.R. § 718.201(a)(2).

I also note that the legal definition also includes the term, silico-tuberculosis, arising out of coal mine employment. 20 C.F.R. §718.201.

I note that the Claimant had been treated for pneumoconiosis for three years by Dr. Forehand due to sputum production, daily, exertional wheezing, daily, exertional dyspnea when walking and climbing, cough, and 2 pillow orthopnea. Dr. Spagnolo opined within a reasonable degree of medical certainty that Claimant appears to have had sufficient exposure to coalmine dust to result in pneumoconiosis. Dr. Castle noted that Claimant worked in or around underground mining long enough to have developed coal workers' pneumoconiosis if he were a susceptible host, worked in surface mining for approximately 17 years as a driller/shooter, and was a lifelong nonsmoker. I find that the 11 plus years is not an impediment. He did not directly address the distinction between clinical or legal pneumoconiosis but his description of the exposure is consistent with legal pneumoconiosis. Although Dr. Repsher found "possible" pneumoconiosis, he found no breathing deficit, but his testimony is conflicted because at one point in the record, he diagnosed clinical pneumoconiosis. EX 26.

I find that the "other medical evidence" is interesting, but not dispositive on whether either clinical or legal pneumoconiosis has been established in this record. CT scans and MRIs must be weighed with, "other medical evidence" under § 718.107. The Claimant relies on reports from Dr. Daniel J. Fowler who noted fairly diffuse reticulonodular scarring, larger irregular densities in both upper lobes, and COPD in the lungs, compatible with benign complicated pneumoconiosis. (DX 151) and Dr. David Groten also interpreted the February 2, 2005 CT scan as most likely reflecting complicated pneumoconiosis. Dr. Sacatarige read the same CT scans and found that they likely showed TB, and ruled out pneumoconiosis. I find that neither the Claimant nor Employer laid the proper predicate to show that CTs or MRIs are reliable in this record, so I accord them little weight.

After a review of the entire record, I give significant weight to the fact that the majority of x-rays that do not diagnose TB are positive for pneumoconiosis, I give significant weight to the expert opinions, the majority of which diagnose pneumoconiosis. I find that Claimant has

established the existence of both clinical and legal coal workers' pneumoconiosis. I find that the opinions of Drs. Castle and Spagnolo provide logic to a finding of at least simple pneumoconiosis in this record. Dr. Spagnolo opined within a reasonable degree of medical certainty that Claimant appears to have had sufficient exposure to coalmine dust to result in pneumoconiosis. I do not attribute "controlling" weight to Dr. Forehand's opinion, but I note that as the treating physician, he treated the Claimant for symptoms that are competent to produce legal pneumoconiosis.

Cause of Pneumoconiosis

20 C.F.R. § 718.203(a)(2001) provides that if a miner who is suffering from pneumoconiosis was employed for ten or more years in the coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of that coal mine employment.

I previously found that Claimant has 11.75 years of coal mine employment. I also find that Employer has not provided evidence that rebuts this presumption. Therefore, I find that Claimant's simple coal workers' pneumoconiosis arose from his coal mine employment.

Alternatively, the Claimant was exposed to coal dust and silica that aggravated any other lung problem he may have had. I credit Dr. Forehand's testimony that the Claimant's coal mine employment generates a mixture of hard rock dusts which places the employee at risk of developing occupational lung disease. Dr. Spagnolo also opined within a reasonable degree of medical certainty that Claimant appears to have had sufficient exposure to coalmine dust to result in pneumoconiosis. Dr. Forehand wrote that Claimant's disabling lung disease arose from his employment as a driller/blaster. I attribute less weight to opinions from Drs. Scott, Scaterige and Wheeler as they do not diagnose pneumoconiosis.

Therefore, I find that the pneumoconiosis was caused by coal mine employment.

Complicated Pneumoconiosis

The Regulations provide an irrebuttable presumption of total disability due to pneumoconiosis when a Claimant is diagnosed with complicated pneumoconiosis. 20 C.F.R. § 718.304. Specifically, the evidence must establish that the miner is suffering from a chronic dust disease of the lung which is manifested by: (a) x-ray opacities greater than one centimeter in diameter and classified as Category A, B, or C; or (b) an autopsy or biopsy which yields massive lesions in the lung; or (c) when diagnosed by means other than (a) or (b), would be a condition which could reasonably be expected to yield the results described in (a) or (b). I must evaluate the evidence for each prong of § 718.304, and then weigh all three prongs together to determine if the irrebuttable presumption has been invoked. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991).

Chest x-ray interpretations under Prong (a)

Of the forty-five chest x-ray interpretations reviewed in connection with this request for modification, three were interpreted as positive for complicated pneumoconiosis and forty-two were negative for the existence of complicated pneumoconiosis. The preponderance of the chest x-ray evidence before Judge Miller was positive for the existence of complicated pneumoconiosis.

However, it is assumed that pneumoconiosis is a progressive disease.

The most recent complicated pneumoconiosis interpretation of an x-ray was taken on January 3, 2006 and interpreted by dually-qualified Dr. DePonte. The same x-ray was

determined to be negative by Drs. Scott, Scatarige, and Wheeler, who are also all dually-qualified physicians.

Drs. Scott, Wheeler and Scatarige all found large lesions, but attribute them to TB. No parenchymal or pleural abnormalities consistent with pneumoconiosis are noted.

Dr. DePonte initially determined that the size of the lesion was ten (10) centimeters but when she measured it at the deposition it was twelve (12) centimeters. CX 3, at 6. It is large enough in size to qualify if it is pneumoconiosis.

Dr. DePonte explained that in order distinguish the opacity from tuberculosis, one looks at the underlying pattern of opacities and TB typically tends to be more superior involving the upper portions of lung apicies, where in Claimant's case, the rounded opacities and the coalescence occurred over the second and third ribs bilaterally and down near the fourth rib on the left. CX 3, 7. She further explained that most of the time, TB is not symmetric and usually doesn't involve bilateral symmetry, unless it is miliary TB, which is blood borne. CX 3 , 8. She testified that opacities caused by rheumatoid arthritis tend to be larger, rounded, and occur more in the lower lungs and other granulosa don't look like the 2006 x-ray. She explained that histoplasmosis typically present as well defined, small, rounded, densely calcified granulosa but you don't get the fibrosis from the coalescence seen here. CX 3, 8-9.

Dr. DePonte testified that the miner's x-ray is a fairly close classic presentation of complicated coal workers' pneumoconiosis and that in her opinion, Claimant really does have pneumoconiosis and [it] doesn't fit the pattern of the other diseases attributed to it. CX 3, 10. She further stated that she thinks pneumoconiosis is by far the etiology of Claimant's pulmonary abnormalities. Id. Dr. DePonte testified that in her opinion, by the presence of what appears to be a large opacity over the anterior left fourth rib, Claimant would meet the criteria of complicated pneumoconiosis. Id.

I note that the Claimant had been tested for TB, and testing was negative. I also note that there is no evidence of treatment for tuberculosis in this record. In reading the opinions, I note that Dr. Sacterige used the term "probably" to describe TB of "uncertain" activity. Drs. Scott did not use "probably," but he used "uncertain activity". EX 44, EX 45. At one point in the record Dr. Wheeler describes lesions "compatible with TB unknown activity probably healed". EX 18. I find that these opinions are less than certain. *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91 (1988) (an equivocal opinion regarding etiology may be given less weight); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236 (1984) (equivocal regarding disability). In an unpublished decision in *Yogi Mining Co. v. Director, OWCP [Fife*], Case No. 04-2140 (4th Cir. Dec. 7, 2005), a judge considered their opinions to be inconclusive, and he chose to rely instead on the unequivocal diagnoses of complicated pneumoconiosis by two other experts, who were also dually qualified. I find that the diagnosis of TB rendered by Drs. Scott, Wheeler and Scatarige are inconclusive.[4]

I also note that although the preponderance of the evidence supports a finding of at least simple pneumoconiosis, Drs. Scaterige, Wheeler and Scott do not. They were not asked to

[4] In ***Cooper v. Westmoreland Coal Co***., BRB No. 04-0589 BLA (Mar. 28, 2005) (unpub.), a judge acted within his discretion in finding that "Dr. Wheeler's and Dr. Gaziano's equivocal identification of TB as the disease process that accounts for the markings that other physicians have identified as complicated pneumoconiosis diminishes their credibility."

address whether legal pneumoconiosis was present. I find that their opinions are entitled to less weight as a result.[5]

Moreover, I also note that the legal definition also includes the term, silico-tuberculosis, arising out of coal mine employment. 20 C.F.R. §718.201. Alternatively, it is reasonable that Drs. Scott, Scaterige and Wheeler imply that tuberculosis and pneumoconiosis are mutually exclusive.

Dr. Repsher testified that he cannot rule out simple coal workers' pneumoconiosis but he can rule out complicated coal workers' pneumoconiosis. EX 47 at p. 24. He is not a dually qualified radiologist, so I attribute little weight to this opinion. Moreover, he acknowledged that pneumoconiosis can be progressive, but testified that it is "rare". I find that this is inconsistent with the law. Moreover he testified that because rounded opacities were seen in all zones, they were not indicative of pneumoconiosis, and that TB may be a more apt diagnosis. I discount this opinion. Dr. DePonte testified that the coalescence of smaller rounded opacities were in the upper lung zones, just below the apicies. CX 3 at p. 6. Not only is Dr. Repsher factually incorrect, he assumes that all pneumoconiosis manifests itself in the same way.

A better rationale is that TB is not a good explanation for the reading of the January 3, 2006 x-ray. In the deposition, Dr. DePonte was asked:

> Q: How can you tell that that opacity is not caused by tuberculosis for example.
>
> A: A You look at the underlying pattern of opacities. You have the background of the small rounded opacities as it's occurring in that location. Also, typically, TB tends to be more superior involving the upper portions of the lung apicies, where in this case, these rounded opacities and the coalescence, where they're more numerous occurred over the second and third ribs bi-laterally and down near the fourth rib on the left. Whereas, if you look over the first ribs, bi-laterally those areas are relatively clear.
>
> Q: What about a granulosa process. How is that different from the granulosa process?
>
> A It depends upon which granulosa process you're talking about. If you're talking about TB, these are not the typical opacities. I have seen cases of active TB over the years. Usually they're much more into sync. You can get some scaring from that. You can see fibrosis with this. Most of the time with TB, it's not symmetric. You know, it's an infectious process. It usually doesn't involve bilateral symmetry, unless it's miliary TB, which is blood born. In this case the interstitial lung disease is fairly symmetric. And, again with the background of the smaller opacities. Another way to say that it is not TB, is to look at the stability of this over a period of time. Unfortunately, I do not have other films on this gentlemen, but if he has had them elsewhere, then, that information would aide in confirming these findings.
>
> Q What about opacities caused by rheumatoid arthritis?

[5] In ***Deel v. Buchanan Production Co.,*** BRB No. 06-0188 BLA (Nov. 30, 2006) (unpub.), the Board held that, where a radiologist concludes that abnormalities on a chest x-ray are consistent with tuberculosis or other diseases, the administrative law judge may not discredit the opinion solely on the basis that there is no other medical data of record demonstrating that the miner suffered from tuberculosis. In this vein, the Board concluded that "[t]he fact that the record does not reveal that claimant suffered from tuberculosis does not undermine the interpretations of those physicians who found that claimant's x-rays revealed abnormalities consistent with that disease." However, here, there is a better explanation provided by Claimant's experts as to the absence of TB, there is negative testing, there is no treatment and the Employer physicians rendered equivocal statements.

A Those tend to be larger rounded and more indistinctly occur more in the lower lungs, because that's where the greatest blood flow is. Other granulose disease, such as fungal diseases, typically don't look like this. You can have hystoplasmosis which is one that is often brought up as it's a common disease. Typically those present as well defined, small rounded, densely calcified granulosa. And then throughout all of the lung zones, you can get some upper low predominance. But you don't get the fibrosis from the coalescence that you see here. And, I have seen cases of hystoplasmosis. In fact, I have had film sent to me for black lung that's really hystoplasmosis. The radiographic appearances are very characteristic. Sarcoid in consideration, that's another granulosa disease, uncertain etiology, some postulated infectious processes but it's not really known. That tends to involve the lymphs. It's all associated usually with bi-lateral lymphadenopathy, which is one of the hallmarks. The interstitial findings tend to be more diffused, and not so focal at the coalescence as the….

CX 3, 7-9.

After a review of the entire record, I attribute greater weight to the opinion of Dr. DePonte, I credit her explanation regarding her diagnosis as the most rational in this record, and accept that the Claimant has provided evidence of complicated pneumoconiosis by x-ray.

I find that the most recent x-ray evidence is more probative of the existence of complicated pneumoconiosis.

Autopsy or Biopsy evidence under Prong (b)

There is no autopsy or biopsy evidence in the record; therefore, complicated pneumoconiosis can not be established under Prong (b).

Diagnosis by other equivalent means under Prong (c)

Prong (c) provides that the irrebuttable presumption may apply when the miner suffers from a chronic lung disease which, when diagnosed by means other than those specified in Prongs (a) and (b), would be a condition that could reasonably be expected to yield the massive lesions described in Prongs (a) and (b). § 718.304(c). In this case, the other medical evidence in the record consists of CT scans, an MRI, and physician medical opinions.

There are fifteen interpretations of six CT scans which were taken on November 7, 1996, November 12, 1998, November 2, 2000, August 19, 2004, February 2, 2005, and April 1, 2005. However, I do not accept that the "other" medical evidence is useful in this record as the reliability for its use has not been established. Accordingly, as Claimant established the existence of complicated pneumoconiosis via x-ray, I find that he is entitled to the irrebuttable presumption and that he has not experienced a change in conditions.

I also accept that the January 3, 2006 x-ray is new and that the opinions expressed by the internists and pulmonologists as to present evidence of complicated pneumoconiosis have little significance, given the progressive nature of pneumoconiosis.

CONCLUSION

In the prior record, Dr. Forehand interpreted the July 1, 1996 x-ray as positive for complicated pneumoconiosis, Category A, without explicitly identifying any large opacities (DX 22). Dr. DePonte interpreted the January 5, 2001 film as positive for complicated pneumoconiosis, Category A, without explicitly identifying any large opacities (DX-99). I note that there was an attempt to cure this at CX 3, 16, but the report failed to render an identification

of the size of the x-ray at that time. The Claimant had the duty to prove the size aspect by a preponderance of the evidence and failed to do so.

However, I accept that the new evidence shows that by January, 2006, probative x-ray evidence of complicated pneumoconiosis exists in this record.

But prior to that, the Claimant failed to establish that he has complicated pneumoconiosis and he also failed to establish total disability, and was not entitled to benefits due to failure to prove an essential element of the claim. In order to establish total disability, Claimant must establish by a preponderance of the evidence that he has a pulmonary or respiratory impairment, which, standing alone, prevents him from performing his usual coal mine work or work requiring similar skills. 20 C.F.R. § 718.204. In addition, Claimant must establish that pneumoconiosis is a contributing cause of his totally disabling respiratory impairment. The Regulations provide the following methods for establishing total disability: 1) pulmonary function studies; 2) arterial blood gas studies; 3) evidence of cor pulmonale with right-sided congestive heart failure; 4) reasoned medical opinions. 20 C.F.R. § 718.204(b).

None of the pulmonary function studies in the record produced qualifying values. In addition, a pulmonary function study performed on November 10, 2002 at Duke University revealed an FEV 1 of 2.65, FVC of 3.72 and an MVV of 85. The FEV1/FVC was 71%. However, Claimant's age and height are not noted on the record and there are no accompanying tracings. Consequently, this study is invalid. As none of the valid pulmonary function studies produced qualifying values, Claimant cannot establish total disability pursuant to 20 C.F.R. § 718.204(b)(2)(i).

Of the four arterial blood gas studies in the record, only the exercise portion of the pulmonary function study submitted in connection with this request for modification, taken on July 8, 1996, produced qualifying results. However, as previously noted by Judge Miller, the validity of this study was disputed by Drs. Castle and Iosif. Dr. Castle explained that the abnormality could not be a result of coal workers' pneumoconiosis because when coal workers' pneumoconiosis causes hypoxemia, it is permanent and does not revert or become normal with time. Subsequent resting arterial blood gas studies were non-qualifying, including the study taken at Duke University in 2002, and Claimant could not perform another exercise study because it is contraindicated due to his hypertension. Accordingly, I find that the positive exercise study is outweighed by the subsequent non-qualifying and more recent arterial blood gas studies and the reasoned opinion of Dr. Castle. Therefore, Claimant has not established total disability with the arterial blood gas study evidence under 20 C.F.R. § 718.204(b)(2)(ii).

There is no evidence in the record that Claimant has cor pulmonale with right-sided congestive heart failure. Therefore, total disability is not established by 20 C.F.R. § 718.204(b)(2)(iii).

Of the physicians providing medical opinions addressing total disability, only Dr. Forehand opined that Claimant is totally disabled from a respiratory or pulmonary impairment. Drs. Dahhan, Spagnolo, Castle, and Repsher all opined that Claimant retains the respiratory capacity to perform his previous or similar coal mine work. All of the physicians based their opinions on Claimant's objective studies, physical examinations, and occupational history; therefore, they are all well documented. However, Dr. Forehand did not explain the basis of his opinion with respect to the uniformly non-qualifying pulmonary function studies, or the fact that there was only one non-qualifying, non-reproducible x-ray study. In addition, as opposed to the other physicians, Dr. Forehand did not address Claimant's numerous other medical conditions

and any impact they might or might not have on his physical status. Therefore, I find that his opinion is not as well reasoned as the contrary opinions.

In terms of qualifications, Drs. Dahhan, Spagnolo, Castle, and Repsher are all board certified pulmonologists, while Dr. Forehand specializes in pediatric allergy, and immunology. Accordingly, I find that he is not as well qualified as the other physicians. Because I find the opinions of Drs. Dahhan, Spagnolo, Castle, and Repsher to be better reasoned and that they are better qualified, I find that their opinions are entitled to controlling weight. Consequently, the preponderance of the medical opinion evidence does not establish that Claimant is totally disabled due to a respiratory and pulmonary impairment prior to January 3, 2006.

ENTITLEMENT

I find that although Claimant failed to establish a mistake of fact, he has established a change in condition and therefore has established entitlement to benefits. Pursuant to 20 CFR §725.503, benefits are payable as of the month of onset of total disability and if the evidence does not establish the month of onset, benefits are payable beginning with the month during which the claim was filed.

The Claimant was evaluated by Dr. DePonte in January, 2006. CX 2, CX 3. I accept the determination that the Claimant was totally disabled due to pneumoconiosis at that time.

Therefore, I find that benefits are payable as of the month during which Claimant proved disability, January, 2006.

Attorney's Fees

No award of attorney's fees for services to the Claimant is made herein because no application has been received from counsel. A period of 30 days is hereby allowed for the Claimant's counsel to submit an application. ***Bankes v. Director***, 8 BLR 2-l (l985). The application must conform to 20 C.F.R. 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet showing that service has been made upon all parties, including the Claimant and Solicitor as counsel for the Director. Parties so served shall have 10 days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge the Claimant any fee in the absence of the approval of such application.

ORDER

The claim for benefits filed by **R.B.** is hereby **GRANTED**.

A

DANIEL F. SOLOMON
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington,

DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).